Psychosocial support for refugee children and families

HELLENIC REPUBLIC
National and Kapodistrian University of Athens
EST. 1837

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In memory of ***Pierre Eichenberger***
who gave voice to refugee children and who
advocated for their rights through art

Merimna

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“Merimna” (the Greek word for Care) is the only organization in Greece which provides bereavement support services free of charge for children, families, schools and local communities mourning the loss of people of significance to them. Merimna also provides pediatric palliative home care services to children with life-threatening conditions and to their loved ones. This non-profit organization (www.merimna.org.gr), was founded in 1995 by experts in palliative care and bereavement support. More than 50,000 children have benefited from the bereavement services offered by “Merimna” through its two Childhood & Family Bereavement Counseling Centers as well as by on-site community interventions after traumatic losses or mass disasters.

Photos

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After having walked 20 klm...

Foreword

With a view to empowering mental health professionals supporting refugee children and families, the Greek non-profit organization for the care of children and families facing illness and death, "Merimna", has implemented the project "From Adversity and Loss to Resilience: Psychosocial Support for Refugee Children and Families" with the support of UNICEF and funding from the European Commission (Department of Civil Protection and Humanitarian Aid).

The aim of the project is to offer training, supervision and support to field workers providing psychosocial services to children and parents living in camps in Northern Greece through the Child and Family Support Hubs "Blue Dots", and to those who work in civil organizations supported by the National Center for Social Solidarity (EKKA).

During the project there was a rich exchange of knowledge and clinical experience between psychologists and social workers working in the field. In addition, the unique aspects of the experience of refugees while living in Greece were illuminated. For the overwhelming majority, our country is a "passage", a "stopover" in their search for settlement in a European country that will enable them to rebuild their lives. However, there are very long delays in handling applications for asylum, for resettlement or for family reunification, while at the same time an inhospitable climate is developing in most European countries. The mental health of refugees is deteriorating because they are living in this context of ambiguity and uncertainty, and immobilized by the prolonged waiting. Thus striving for a balance between acknowledging the refugees' vulnerability and fostering their resilience remains a key challenge for mental health professionals who assume a supportive role.

This booklet has three objectives: firstly, to describe some of the losses and traumatic experiences encountered by refugee children and families currently living in Greece; secondly, to describe both normal and some dysfunctional reactions of children and adolescents growing up in a world rife with adversity and challenges; and thirdly, to offer some guidelines that will enable an understanding of the inevitable suffering caused by multiple losses and traumatic experiences, and a fostering of resilience in the children and their parents. The content of this booklet is applicable only to refugee children accompanied by one or both parents or an adult responsible for their care. While the basic support principles described also apply to unaccompanied minors, they do not reflect the unique challenges they experience, or the impact on their mental health. Particular emphasis is placed on the "in transit" condition experienced by refugees who are currently stranded or confined in a country they had neither planned nor wished to settle in.

We hope the content of this booklet will provide field workers with opportunities for reflection, orientation and empowerment in their work with children and adults who have been forced to become refugees.

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1

Forced migration: On the crossroad of cultures

Refugees are like tortoises. Wherever they go, they carry their home with them, namely, their culture - the beliefs, values, rules, traditions and practices that define their identity or who they are. To understand the psychosocial effects that refugee status has on children and their parents, we must first acquaint ourselves with the "home" they carry, while acknowledging and taking into consideration that those belonging to the same culture are not "identical" to each other. They do not necessarily share the same values, way of life, religious influences, nor do they have the same socio-economic and educational level.

Whatever their socio-cultural differences, all refugee families have faced a life-threatening situation involving war, conflict, violence, torture or threat of conscription, which has forcibly uprooted them from their home and led them to seek security in another part of their country (internal relocation), in a neighboring country or on another continent.

In most of the countries from which refugees originate the system of values differs from most European cultures. In an attempt to avoid a dichotomous classification of cultures into "Western" and "Eastern" and in consideration of the variability of alternative attitudes, beliefs and behaviors, even among people belonging to the same culture, Laungani (2004) proposes a conceptual model which attempts to explain similarities and differences between Eastern and Western cultures in terms of four interrelated value systems that guide and influence behavior and explain how people perceive themselves and the world.

Laungani postulates that these value systems vary on a continuum where the extremes depict two diametrically opposite orientations. Values of individuals, communities and societies vary on this continuum depending on cultural, social and religious backgrounds.

Individualism ——— ***Communalism - collectivism***

Individualism refers to values that promote the individual's ability to control and plan their life, operate autonomously, pursue desirable goals, and take responsibility for their own decisions and actions. Collectivism is associated with values that promote the "common good" of the family and community. The family is governed by a hierarchical model where the role of its members is predetermined. To belong, one must adapt to the rules and wishes of the whole group and contribute to the pursuit of collective goals.

Cognitivism ——— ***Emotionalism***

In cognitively oriented societies, all decisions and actions rely on rationality and logic, while emotions are kept under control. Emphasis is placed on the individual's active involvement, pursuit of goal-oriented tasks and high achievements. The identity of the individual is determined by what he or she has achieved, especially at the professional level, which is highly valued by society. In contrast, societies oriented towards interpersonal relationships attach greater importance to the positive or negative emotions which characterize interactions. Emotions are openly shared as long as they do not threaten the hierarchy of family and social relations.

Free Will ——— ***Determinism***

Freedom of choice and self-determination are core values of Western societies, which strive for success and avoidance of failure. In societies where freedom of personal choice is limited, successes or failures are attributed to God's will, to the individual's karma, or to other extraneous factors which are accepted without protest.

Materialism ——— ***Spiritualism***

The perception that the world is objective and measureable, affects the values of Western societies which focus on scientific evidence to explain the existence of specific phenomena and their interpretation (e.g. mental illness, aggression). The individual's success in life is measured by his or her possessions (e.g. money, houses, land). In contrast, in Eastern societies, external reality is considered "deceptive" and "changing". The goal of human existence is to develop beyond material dependence and reach higher levels of consciousness through meditation, prayer and faith in a metaphysical world.

The meeting between people of diverse ethnic backgrounds may "enrich" not only refugees settling in a new country but also the people of the country which integrates them. This requires openness on the part of the hosts to what is perceived as "foreign", "unfamiliar" or "different" in terms of value systems or views of human relations and the world. At the same time, it requires a genuine interest in diversity and whatever novel experiences it may bring. The ability of a country to welcome, accommodate and secure dignified living conditions for refugees and their families is an indication of both its humanity and its ability to evolve and become enriched through the creation of a social framework where "We" is superior to "I " and to the "Other ".

2

From home... to a new “homeland”:
The trajectory of the child and family

The story of becoming a refugee begins with the family’s decision to flee its land of origin. Some families with connections and financial resources relocate without much delay to the desired country. Others move from country to country for many years, some settle down in a place and a very few are voluntarily repatriated. The journey from home to host country comprises four stages which are briefly described here.

1st stage: The flight: A family decision

At this stage, usually the parents with the consent of the wider family decide to flee together or separately with all or some of their children. Sometimes the decision is made instantaneously when it comes to survival, but is more usually planned by the wider family who decides who will go first, who will follow and who will stay behind. These family decisions have an impact on those who are forced to leave their homeland, on those who stay behind, but also on relatives who have already settled in another country and await children and parents seeking refuge.

As the journey begins, a new chapter opens up in the family’s story and relationships among its members. If the couple has disagreed on decisions regarding the flight from home, then blame, guilt and anger may affect their marriage. Sibling bonds may also be affected when brothers and sisters are separated, grow up under different circumstances, fall victim to human trafficking, go missing or die.

Questions for understanding the experience of forced flight and the psychosocial impact on family members

- *What living conditions in their country of origin contributed to their decision to flee?*
- *When and why was the decision to flee made?*
- *Who participated in the decision-making process?*
- *How was the decision made? Did a parent have to back down, be coerced, have doubts, or be sacrificed?*
- *How did the extended family participate in the decision?*
- *Was there any preparation and planning?*
- *What was said to the children?*
- *How was communication maintained with significant others after the flight?*
- *Did significant others contribute financially or continue to support the family's journey? What kind of support do they provide?*
- *Are there any regrets over particular decisions?*

2nd stage: The family on the move - Challenges and adversities

The journey often involves many challenges and risks, which are discovered en route. Some parents and children travel alone, others in groups of compatriots. They experience inhumane conditions without access to water and food and occasionally stay in crowded camps for longer or shorter periods.

Some experiences such as imprisonment, separation or the death of a family member are highly traumatic. Families often fall victim to exploitation by smugglers, traffickers and organized crime groups who threaten their lives, steal their money and belongings, and rape or inflict violence on family members. Moreover, they are also exposed to racism and xenophobia as they journey across various countries.

These adversities may cause some families to fall apart, while others draw closer to each other, developing new skills and psychosocial resources. Some children enjoy a closer relationship with their parents and learn to cooperate when in danger, while others experience serious psychological problems, especially when their mother and father struggle to cope with adversities and have difficulty functioning effectively in their parenting role.

Questions for identifying the challenges that the family has experienced in its journey to Greece

- *Why did the family choose to settle in Europe?*
- *What difficulties did they encounter on the way?*
- *How did they cope with and find meaning in these difficulties?*
- *How were family members -adults and children- affected by adversities?*
- *Had there been any internal relocation or stay in refugee camps of other countries before arriving in Greece? If so, for how long and how was this experienced?*
- *Were there separations, deaths, injuries or illness during their journey? If so, how did they cope at the time, and how do these experiences affect them now?*
- *What positive experiences have emerged along the way?*
- *What gave parents and children their strength and courage?*
- *How family relationships were affected and how did family roles change?*
- *Have there been any changes in the quality of parental care and/or in the practices and rules of raising the children?*
- *How were decisions made and by whom?*

3rd stage: In limbo: The “in transit” condition

At this stage parents and children, suitcase in hand, await the legal decisions which will determine the next steps of their journey. For the large majority of refugees, Greece represents a “stepping stone”. This results in most of them living in an “in transit” situation.

The uncertainty of their future is insupportable. Under these circumstances, for the first time, many children are exposed to the mental suffering of their parents who, helpless and inactive, are incapable of determining the future of their family. The psychological distress caused by their immobilization is manifested in some parents through psychosomatic or psychological problems, while others resort to the use of alcohol and drugs, which sometimes leads to domestic violence. Meanwhile, adolescents, unable to bear the sense of inactivity and uncertainty, seek extreme emotional experiences which may lead to acts of individual or collective violence. Other youngsters are consumed with the fear of re-living past traumatic experiences, which they are unable to cope with in this limbo.

Recent reports (Save the Children 2017; Médecins Sans Frontières, 2017; The FXB Center for Health and Human Rights, Harvard University, 2017) highlight the enormous challenges faced by refugees and immigrants trapped in Greece and living in insecure and undignified conditions which result in serious deterioration of their mental health.

Nevertheless in this transit condition, some children welcome a “break” in their journey, especially when living conditions are safe and they are provided with opportunities for cognitive, emotional and social development in a supportive environment. In other words, the ‘in transit’ condition brings a sense of relief, especially if their journey had been marked with hardships and losses. It allows them to establish a routine, benefit from play and creative activities, attend school, develop relationships with other children and revert to their usual habits and misbehaviors. Thus, in the midst of a transition, they construct “normality” and establish a new sense of order in their daily life which helps them to focus on the present.

Questions to explore the psychosocial impact of the "in transit" condition

- *How do parents, teenagers and children experience living conditions in Greece?*
- *How safe do they feel?*
- *What difficulties are they facing today? How do they cope with them and how do they assign meaning to them?*
- *What worries them the most and causes them stress?*
- *What satisfies them? What positive experiences are they having and from which opportunities are they benefitting?*
- *How do they manage the stress caused by the wait for asylum, relocation or reunification with their family members?*
- *How does stress affect relationships and roles in the family?*
- *What helps them manage their daily lives effectively?*
- *What contact do they maintain with family, relatives and friends in their home country?*
- *What relationships do they maintain with fellow compatriots? What contact do they have with refugees from other nationalities?*
- *Which available services (e.g. health, mental health, legal, educational) do they use and how do they benefit from them?*
- *Which needs are not met?*
- *What are their plans for the future? How do their plans today, compare with those they had when they were forced to flee?*
- *What are their dreams for their children?*

4th stage: Relocation in the host country

Relocation involves new challenges for family members. In an attempt to maintain their ethnic identity, the family often adheres more closely to their own cultural values, traditions, customs, religious and political beliefs. In this new environment where the host country is trying to integrate them, the family is often confronted with stereotypes of "the foreigner".

Children and parents swing between the "new" and the "different", that the host environment brings, and the "familiar", embodied by their traditional life style. The family's integration into the new country depends largely on the flexibility of its members to find a balance between the new values, habits and practices (leaning towards change) and the preservation of its cultural identity (leaning towards the preservation of tradition). Their integration is further facilitated when the family has contact with others of a similar background and experience who provide them with a social network and a sense of "continuity" between the past, the present and the future. In addition they are helped further when the host country integrates refugee families without marginalizing them.

Children adopt new values and adjust to their new environment more quickly than their parents do through attending school, acquiring a new language and integrating into peer groups. This may lead to family conflicts when some traditions, values and rules are challenged or overturned by them. The children's faster integration leads them to take on adult responsibilities to such as assisting their parents and representing them before the authorities and institutions of the host country (El-Khano,et al., 2015).

When relocation involves family reunification, the sharing of experiences lived during the period of separation may facilitate mutual understanding, mutual support and a joint rebuilding of the family story following the flight from the homeland and the seeking of asylum in another country. However, when experiences are not discussed because of their traumatic nature, splitting occurs between the parental couple, resulting in the children taking the side of one or the other parent. In these circumstances, the family is threatened with disintegration and the unprocessed experiences are passed on to the next generation.

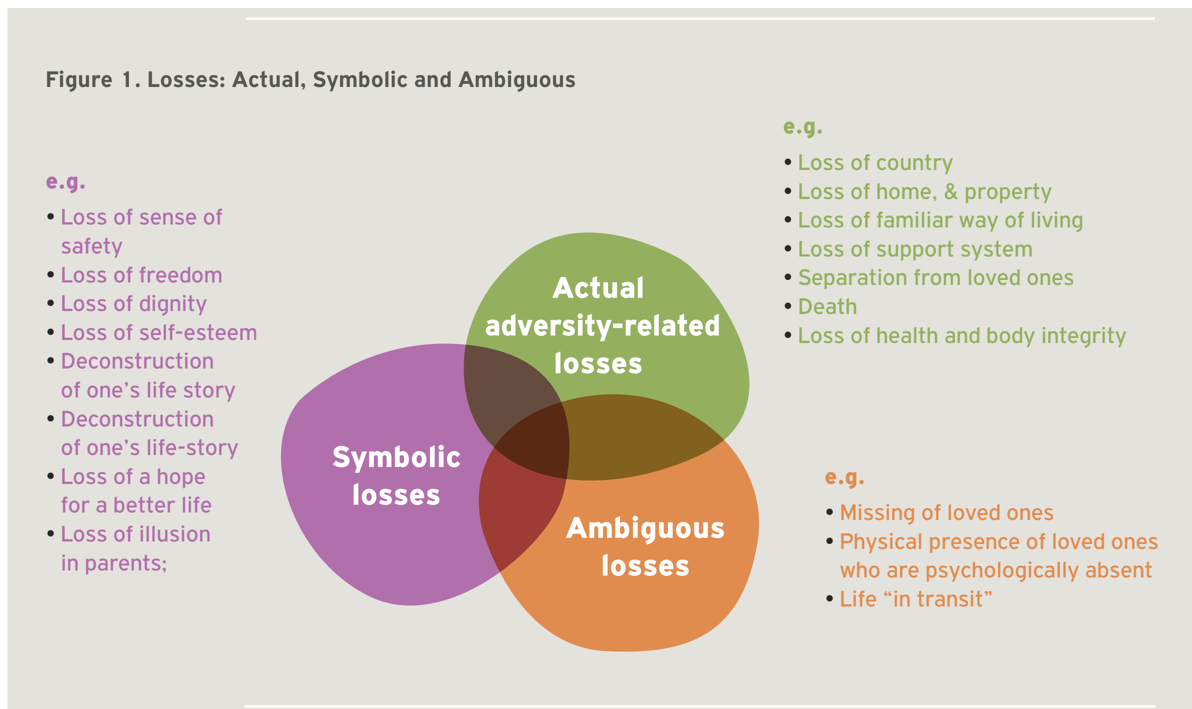
3

Losses, grief, and psychological trauma

3.1. Losses

Both during their flight from their homeland and journey to safety, children experience multiple stressful events and hardships which involve losses. Often these experiences provoke a healthy grieving process which inevitably causes suffering. Other losses may have been experienced so traumatically that they inhibit or complicate the grieving process. Actual, symbolic, ambiguous or parallel losses are briefly described below along with the common responses they provoke.

Figure 1. Losses: Actual, Symbolic and Ambiguous



Actual, adversity-related losses. When children are fleeing, they lose not only their home and property, but also their neighborhood, school, relatives, friends and familiar lifestyle. Particularly painful losses include the death of and separation from parents, siblings and significant others as well as illness, injury and loss of bodily integrity.

Symbolic losses. Particularly painful, especially for pre-school children, is the loss of the illusion that their parents are omnipotent and able to protect them from dangers and threatening situations. Along with this, they lose a sense of security and experience "unthinkable anxieties" towards a world that threatens to annihilate them.

Mohammed's father hugs his son after their rescue. The overloaded boat was at risk of sinking. All the occupants were knee deep in icy water. Mohammed sees his father crying for the first time.

Another symbolic loss involves changes in family dynamics with relationships becoming either intensely close (symbiotic) or estranged (avoidant) with the result that, for the first time, children become exposed to parental domestic violence, social withdrawal or mental disorganization. Some may then take on a caring or protective role towards a desperate parent or their younger siblings.

Mohammed's father hugs his son after having been rescued. Their overloaded boat was sinking and icy water had reached the refugees' knees. Mohammed sees his father crying for the first time in his life.

For adolescents, symbolic losses are associated with the shattering of the belief that the world is predictable and under their control. When they are subjected to exploitation, abuse, racism and humiliation, they experience symbolic losses of safety, freedom, dignity, identity and sense of belonging which are often more painful than the actual losses caused by forced migration.

Ambiguous losses. The most characteristic ambiguous loss is the physical absence of a family member who is missing due to abduction, disappearance, torture, human trafficking, shipwreck or lack of communication and who remains psychologically present in the life of his or her loved ones (Boss et al., 2011). The fact that adults and children know nothing about the loved one's fate raises terrifying fantasies that overwhelm their thoughts and emotions. The lack of information intensifies the family's search to learn what has become of its' beloved member. This leads to the gathering of scattered, often unsubstantiated rumors in an attempt to create an imaginary scenario of events and construct a narrative that fills the unbearable vacuum of absence. Without any proof of death, the family by keeping the missing person "alive" is unable to grieve. With no knowledge of whether the person is suffering, is dead or alive, hope is maintained. The absence of death rituals further exacerbate the pain caused by the ambiguous loss.

Another type of ambiguous loss involves the "loss" of a loved one who, even though physically present, is psychologically absent as a result of having changed to such an extent that he or she is no longer recognizable. For example, children may feel that they have "lost" a parent who has become "another person" as a result of being depressed, indifferent, violent and/or abusive and they may have difficulty relating to him or her.

The "in transit" living conditions in themselves can be considered ambiguous losses in that they give rise to ambiguity and uncertainty as to whether or not the family's goals, dreams and aspirations will ever be realized.

Questions to a child whose parent is missing

- *Who do you consider to be your "family"?*
- *How does the absence of your parent affect you?*
- *What do you think happened and why is your parent missing?*
- *How does his/her disappearance affect your family?*
- *What has changed in your relationships within the family?*

Other parallel losses. Some refugees also experience anticipated losses when they know that they will part from people with whom they have developed close bonds during their temporary stay in camps or shelters. These losses give rise to an anticipatory grief process which, though painful, prepares them mentally for the impending separation. However, some children and adults refrain from developing bonds with field workers or other refugees in order to avoid the pain of separation as it means re-living previous losses and partings.

It is important to remember that the suppression of grief in a family striving to survive under adverse living conditions results in losses that remain unexplored and unprocessed. Such losses may have been experienced prior to the flight (e.g. death of a family member, unemployment, abuse, neglect), during the flight or while on the move.

Along with any of the above losses, all children experience developmental losses. These losses are necessary, as they allow them to leave behind acquired emotional, cognitive, behavioral and social skills in order to develop new and mature ones.

3.2. Grief

Grieving is a healthy and normal process that occurs when an event or experience is perceived as a loss. This process involves a laborious effort to adapt to a world where a significant person, place, goal or other attachment is lost. Grieving is something that people “do”, not something that passively “happens” to them.

A significant loss often challenges the individual’s assumptions about the meaning of life. Grieving helps the bereaved person to reconstruct a new life story in order to regain a sense of coherence and meaning. Psychological suffering is integral to the process of grieving and to a gradual adaption to new life conditions. The loss is neither “forgotten” nor “overcome”, but is progressively integrated into the person’s life story.

Normal grief reactions

There is no right or wrong way of grieving. Every adult, adolescent or child has their own unique way of experiencing and expressing their grief in a given temporal, social, and cultural context. Some of the most common grief manifestations are the following (Worden, 2001, 2009):

Cognitive manifestations

- Denial
- Distrust
- Confusion
- Sense of unreality (It can’t have happened!)
- Meaning-making (Why?)
- Existential concerns and questions
- Concentration problems and problem-solving difficulties

Emotional manifestations

- Shock
- Sadness
- Anger
- Irritability
- Guilt and self-reproach
- Loneliness
- Diffused anxiety or separation anxiety

Behavioral manifestations

- Outbursts of anger or tears
- Mood changes, cyclothymia
- Regression - in children who manifest behaviors of previous developmental stages (e.g. thumb sucking, enuresis, attachment to adults)
- Changes in interpersonal relationships (e.g. aggression, introversion)
- Isolation or withdrawal from family, friends and pleasant activities
- Relief of stress through overactivity i.e. keeping very busy

Physical sensations

- Headaches, migraines
- Upset stomach, gastrointestinal disturbances
- Tachycardia, heart pain
- Muscle weakness
- Allergies (e.g. rashes, asthma, itchy skin)
- Lack of energy, fatigue, dizziness
- Vulnerability to illnesses (e.g. viral) or accidents
- Changes in eating habits (weight loss or gain)
- Sleeping difficulties

Challenges faced by anyone supporting children and families who are experiencing losses

- *To maintain a clear view of both their vulnerability and their resilience and create a space for honoring their losses and suffering.*
- *To acknowledge the different "world" from which refugees come and to show respect for their cultural heritage.*
- *To be flexible and creative in the interventions proposed.*
- *To show respect for and trust in the abilities of children and adolescents, including their choice to remain silent, especially when they live in "transit" situations.*
- *To remove the "white coat" of the mental health specialist and "accompany" children and families in their daily lives.*

It is necessary to develop a bond of trust in order to accompany a child, adolescent or family throughout their grieving trajectory. A supportive approach entails the following skills:

- To recognize the losses without underestimating how much and how differently they affect each family member.
- To encourage parents and children to share thoughts, communicate feelings, allow themselves to be sad, function at a slower pace and express their suffering in any way they wish.
- To allow them to remain silent if they wish to do so; thus not to pressure them to share their experiences.
- To encourage family members to attribute meaning to their losses in ways that is appropriate to them and/or brings them some relief (e.g. God's will, Karma).
- To facilitate the revision of dysfunctional beliefs (e.g., "I am to blame for everything") and/or the regulation of negative emotions (e.g. hate, cataclysmic guilt) which immobilize and entrap them.
- To help them review their priorities, values and goals.
- To encourage them identify and benefit from psychosocial resources that lessen their suffering.

Remember that children and families who are mourning their losses and integrating them into their life story, are also often able to identify some "gains" associated with positive changes in the way they perceive (a) self (e.g. new resources, self-respect, positive self-esteem), (b) relationships with others (e.g. development of empathy, social interest, desire to contribute) and (c) life (e.g. revision of personal values and priorities, focus on what is important and meaningful in life). These positive changes in their perceptions contribute to their 'personal growth'.

Absence of grief

For some families, ambiguous loss causes a lot of suffering. The lack of knowledge about the fate of a loved person who has been abducted or disappeared "freezes" the grieving process. What predominate are confusion, anxiety and inability to attribute meaning to an absence that may be either temporary or definitive and irreversible. Along with the pain of absence, the family also experiences the traumatic effects of uncertainty as to whether their loved one is undergoing torture, is suffering, and is dead or alive. This uncertainty keeps hope alive for a reunion with him or her. Premature acceptance of that person's death and the ensuing grief may result in feelings of guilt and a sense of betrayal or abandonment.

The aim of psychological support is to help the family contain the ambiguity and uncertainty without falling apart and to assist its members to function effectively.

- Recognize and show understanding of the distressing effects of the family member's disappearance.
- Acknowledge as common and normal the fantasies and hallucinations that family members have of their missing person.
- Help them realize that they may have contradictory versions regarding the fate of their missing loved one, which are associated with contradictory feelings, such as hope and despair.
- Facilitate the exchange of views by recognizing a new perception of the family that is created by its members.
- Facilitate the development of realistic expectations and help them accept their lack of control over their situation. Encourage the family to search for information so that they won't be immobilized.
- Help the family build on their support network.
- Remember that hope in these cases is related to the attribution of an "acceptable" meaning with regard to the ambiguous loss.

3.3. Psychological trauma

Psychological trauma occurs when a child or adult is directly or indirectly exposed to an 'out of the ordinary' "extreme" event which, makes demands above and beyond his or her inner resources, giving rise to shock, terror, a sense of helplessness and total lack of control. Traumatic events affect the mental health of a person (psychological trauma) while concurrently being imprinted at a physical level (neurobiological trauma).

The term «psychological trauma" refers to the inability of the child, adolescent or adult to assimilate the experience emotionally and cognitively and to express it verbally or in some other creative way, thus becoming entrapped in re-experiencing the trauma.

Traumatic reactions

Characteristic of traumatic reactions is the re-experiencing of the traumatic event, the concurrent avoidance of any thoughts and feelings it evokes and a state of hyper arousal out of fear of reliving a similar experience. Existential concerns are also common since the person's experience of reality changes, resulting in negative feelings and perceptions of oneself and of the world (e.g. "I am a victim", "I will not get by", "the world is bad and unfair").

Even though traumatic reactions evoke deep suffering, they are normal responses to abnormal events and usually last for a short period of time. They diminish when children and parents are provided with appropriate support in an environment that acknowledges and contains their suffering without denying or minimizing it. The occurrence of traumatic reactions does not necessarily imply a mental disorder.

Table 1 describes for children at each developmental stage (a) the common traumatic reactions, (b) the factors that contribute to a child's vulnerability and (c) the protective factors (resilience).

Table 1. Common traumatic reactions

Common traumatic responses	Vulnerability factors	Protective factors
Infants and toddlers (0-3 years of age)		
• Severe separation distress • Crying and clinging • Sleeping problems • Eating problems	• Limited resources for coping, adult-dependent • Very sensitive to quality of care (inadequate or lack of) • Very sensitive to mother's or caregiver's negative emotional state • Very sensitive to separations • Limited ability for self-control	• Cognitive immaturity • Mother's or caregiver's positive emotional well-being • Family cohesion
Preschool-aged children (4-5 years old)		
• Fearfulness • Vigilance, nightmares • Regression (e.g. bedwetting, thumb sucking) • Separation anxiety, clinging behavior • Sleeping problems, nightmares • Eating problems • Temper tantrums and increased whining • Withdrawal from play or engagement in traumatic play	• Limited resources for coping, still dependent on adults • Very sensitive to quality of care (inadequate or lack) • Very sensitive to mother's or caregiver's negative emotional state • Very sensitive to separations • May believe they are responsible for "bad" things that are happening or for mother's emotional distress (egocentric thinking)	• Cognitive immaturity and limited understanding • Mother's or caregiver's positive emotional well-being • Adequate parenting abilities and skills in adverse conditions • Family cohesion

Common traumatic responses	Vulnerability factors	Protective factors
School-aged children (6-11 years old)		
• Fears • Sleeping problems, nightmares • Irritability, aggression, disobedience • Anger and thoughts of revenge • Withdrawal, depression, anxiety • Disturbing (intrusive) thoughts and images • Concentration problems • Somatic complaints • Temper tantrums and increased whining • Engagement in traumatic play or war games with peers	• Increased ability to perceive, understand and interpret violent events and death • Greater capacity for worrying and thinking about what might happen • Systematic flights of fantasy (e.g. rescue by heroes or by higher powers)	• Ability to ask questions and talk about experiences • Increasing ability to manage negative thoughts and feelings with age • Ability both to support and to get support from peers • Capacity to assume roles and responsibilities that enhance self-image. • Family cohesion • Parent or caregiver with no mental health problems • Good parenting abilities and skills in adverse situations • Adolescents (12-17 years old)
Adolescents (12-17 years old)		
• Aggression and anger • Risky behaviors (e.g. experimentation with drug use) • Disturbing (intrusive) thoughts and images • Masking true feelings – project a facade of effective coping with difficulties, while in reality they experience deep suffering • Existential anxieties and concerns	• Greater direct or indirect (e.g. through information) exposure to traumatic events • Increased anxiety due to a better understanding of their adverse circumstances and the implications for the future • Realistic fears about present and future	• Wider range of problem solving skills and ability to manage adverse situations • Ability to support and be supported by peers • Development of intimate friendshipsand romantic relations • Ability to set goals and to have an orientation towards the future • Spiritual and religious beliefs • Advocacy for their rights • Assuming roles and responsibilities that enhance self-image and esteem • Family cohesion

The key goal in supporting children and adolescents who experience traumatic responses is the acknowledgement of their vulnerability as well as the concomitant enhancement of their resilience. It is important to avoid an approach that pathologizes normal reactions to suffering and classifies all youngsters into "vulnerable groups." Such classification increases the risk of victimization and also neglects the psychosocial resources that individuals bring to and develop under adverse life conditions.

3.4. Helping parents to support their children

The ability of parents to recognize and respond to the emotional and social needs of their children plays a key role in their mental health. It should not be forgotten that in the unacceptable living conditions they find themselves in, parents experience increased and prolonged stress. In the absence of their supportive network and without assuming the familiar roles which defined their identity, some parents experience despair, anger and/or apathy. They withdraw, resort to the use of drugs and/or alcohol, smoke incessantly and are disheartened by the loss of control over their lives.

In order to encourage parents to feel competent in their parental role, we need to understand the challenges they encounter. Alongside the uncertainty about their family's future, they are often faced with challenges associated with the poor hygiene conditions that prevail in some camps, as well as with the safety of their children who are interacting with adults and minors of different cultures and value systems. Some parents are concerned with the children's increase in misbehavior, especially since most come from cultures where respect and obedience to adults are dominant values. Whilst trying to preserve their traditional way of raising children, parents find that authoritarian methods (e.g. spanking, punishment) are criticized by field workers and, as a result, may feel confusion, guilt or even fear of unwanted interference by social services. Under such strain the couple's relationship may be adversely affected regardless of whether they live together or separately; this may further compromise their parenting role and skills.

How can parents support themselves?

A parent who experiences increased distress has difficulty caring for their child in the best possible way. He or she needs to feel understood by field workers who listen with empathy, understand without judging and help them to identify their own difficulties. Field workers or mental health professionals are helpful when they encourage parents to:

- Identify their losses and allow themselves to engage in a grieving process.
- Acknowledge their personal needs and address them in the best possible way.
- Recognize the resources they already have and/or have developed during their journey.
- Seek and receive help from friends, relatives, members of their ethnic community and field workers.
- Establish or redefine daily habits (e.g. regular hours of sleep, food, prayer).
- Keep themselves busy with daily errands and/or engage in activities with others.
- Maintain their religious habits, if they derive strength and courage from them.

How can parents support their child(ren)?

Field workers must explain to parents that it is normal for children to be restless or display behavioral problems after having been exposed to terrifying and highly distressing experiences (see Table 1). Parents need to understand that:

- Children have a different way of reacting when exposed to traumatic experiences and that such memories can cause them a great deal of distress.
- Children need an environment in which they feel safe and free to express themselves.
- Children need to feel understood for what they have experienced or are currently experiencing without being pressured to show certain feelings and to behave in particular ways.
- Children need support from a mental health specialist when their difficulties are chronic and intense.

Guidelines for parents

Security, understanding, support

- *Promise your children that you will do everything in your power to take care of and protect them.*
- *Be affectionate, give lots of hugs, spend time with them and tell them often how much you love them.*
- *Encourage and reward them when they do something well, however small this may be.*
- *Try to be patient without criticizing changes in their behavior.*
- *Show understanding when they burst out crying, become aggressive or regress to earlier developmental stages (e.g. enuresis, thumb sucking, clinging).*
- *Do not minimize their complaints about bodily pains and, after making sure that they do not suffer from a physical problem, provide reassurance.*

Communication

- *Take time to listen and try to understand what they have experienced. Even the quietest child will express him or herself in various indirect ways (e.g. through play, painting). Avoid any superficial reassurance or any pressure to "overcome" their difficulties.*
- *Explain with honesty what is happening. When the future is unclear, share with children the goal you are pursuing and keep the hope alive.*
- *Do not promise things you cannot provide.*

Observing a routine

- *Keep up a routine as far as possible (e.g. regular sleeping hours, lullabies, fairy tales).*
- *Encourage school attendance and participation in activities with other children.*
- *Maintain boundaries and rules, as these create a safe environment.*
- *Praise children when they help you and when they assume responsibilities.*
- *Play with them and encourage play with siblings or other children.*

A useful leaflet for parents, translated into several languages, is the Bundens Psychotherapeuten Kammer (BPtK) (2016) www.bptk.de

What is "post-traumatic" play?

Following exposure to a loss or traumatic event, it is common for children to transfer their experiences into the safe world of play. In play, they distort reality in order to assimilate it, process aspects of their experience and freely express feelings, however strong. After playing the child feels relieved. Over time, the intensity of their feelings gradually decreases.

"Post-traumatic" refers to play in which the child repetitively re-enacts the traumatic event in a compulsive and robotic way without any decrease of anxiety after the play is over. The reliving of the traumatic event may re-traumatize the child and lead to emotional and behavioral difficulties. In this situation, therapeutic intervention by a mental health specialist is needed (Gil, 2010).

Myth: Only through the narration of his or her traumatic experiences is a child 'cured.'

Reality: Narrating a traumatic experience is not an end in itself, since this process can re-traumatize the child. Effective support involves the development of creative activities that help children express their feelings and thoughts and, with appropriate guidance, gradually 'process' their experiences and attribute new meaning to them.

4

Cultivating Psychological Resilience

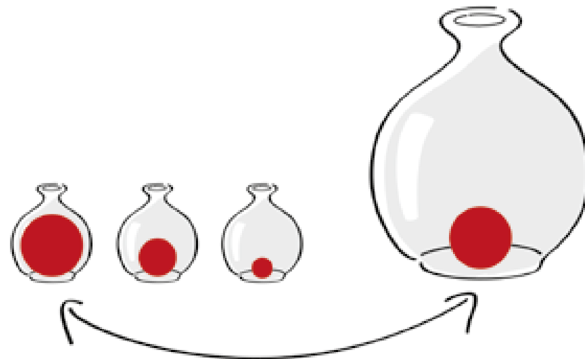
Exposure to traumatic events and adversities may overstretch and exhaust the resources of children and adolescents, who may then resort to less effective strategies and/or rely on adults to manage distressing experiences. Nevertheless, some children display a remarkable ability to cope effectively with loss and trauma.

Resilience is not the ability to adopt an attitude of omnipotence towards difficulties, nor is it the ability to passively endure or withdraw in the face of adverse conditions by suppressing the suffering these may evoke. Instead, resilience comprises the ability to identify difficulties as well as the vulnerability these may engender, together with mobilizing effective coping strategies. In other words, resilience is a dynamic process which involves positive coping and adjustment to adverse conditions.

Resilience is not only affected by the individual personality of a child, adolescent or parent, but also by their relationships with others as well as by their ability to manage difficulties as a family. It is also affected by the social, religious, economic and other resources the family has or develops throughout its journey.

4.1 The resilience of children

Any child or adolescent who has experienced losses and/or traumatic experiences will not necessarily be troubled throughout his or her entire life.



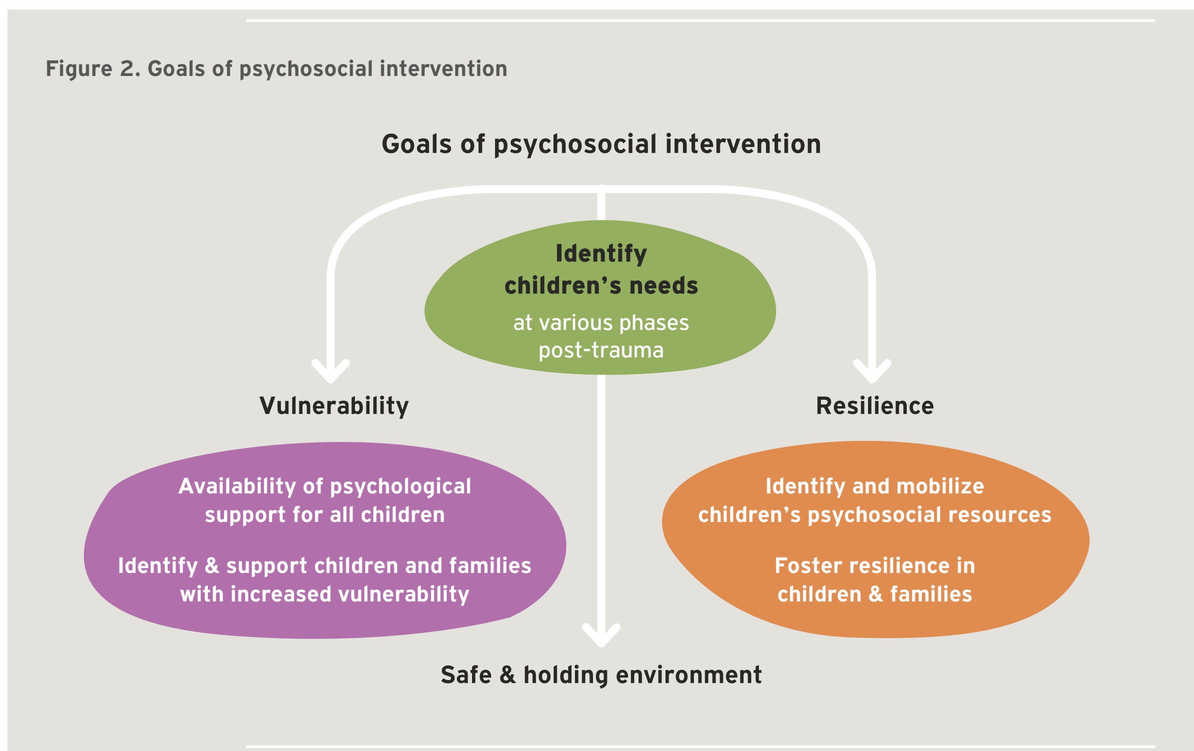
Source: Papadatou, D. & Kamberi, E. (2013) adapted from J. Stokes 2004.

Imagine the losses or traumatic experiences of a child as being a red ball and the child's inner world as a bottle. These experiences which overwhelm his or her inner world do not diminish or disappear over time, as the first three bottles suggest. They always remain “major” and significant experiences in the child's life. With appropriate support, however, the child's inner world may be expanded to contain these experiences and render them an integral aspect of the child's life story, as depicted in the fourth bottle.

The support that is offered to children who have experienced losses and traumatic events has four aims:

- To identify the psychosocial needs of each child, whilst taking into consideration his or her living arrangements.
- To develop a safe and holding environment where children can build trusting relationships and express themselves freely.
- To identify children's vulnerability and offer ongoing support to the entire family, along with specialized services when needed.
- To cultivate children's resilience by enhancing personal, family, social and other resources.

Figure 2. Goals of psychosocial intervention



It is important not to forget that:

- *Many of the "difficulties" that children encounter are normal responses and manifestations of suffering that result from having experienced losses, changes and adversities.*
- *In addition to vulnerability, children may also display signs of resilience.*
- *Vulnerability and resilience in children are affected by the vulnerability and resilience of their parents and vice versa.*

4.2 The resilience of families

Family resilience involves the ability of its members to emerge out of challenging situations more empowered and more resourceful. Factors that contribute to the family's resilience are the following:

- **Safe and dignified living conditions.**
- **A system of values and beliefs** that helps the family attribute meaning to adversities in ways that encourage successful coping, help them to withstand the suffering that has been caused and keep the family's hope alive.
- **A family's ability to manage effectively problems or ambiguous conditions** without falling apart and to adapt flexibly to new situations.
- **Communication and cooperation among family members as well as the parents' ability to function adequately in their parenting role.** Even when living in the camps denies them the opportunity to maintain their usual routine, parents find balance through engagement in new activities, the undertaking of responsibilities and participation in their new community.
- **Benefitting from social networks and available services** (e.g. legal, counseling, education, health services, housing/hosting) which offer emotional and practical support, thus contributing both to the temporary dwelling and/or integration of family members in the host country, as well as to their growth and well being.

Professionals who 'accompany' refugee families should not focus solely on their difficulties and potential psychological problems. By encouraging a reflective approach, they may help family members to identify their personal resources and use them to their advantage so as to cope with choices, decisions and adversities they are presently encountering. Whatever the conditions they face, nothing can deprive them of their freedom to choose how they will deal with daily challenges. Psychological support that focuses on their inner resources can also make it easier to attribute meaning to their experience of being a refugee, and to integrate this into their life story.

Questions to investigate psychosocial family resources

- *What are your needs today?*
- *What can you do to meet these needs?*
- *What strategies did you use in the past to manage difficulties and problems?*
- *How can these strategies be helpful today?*
- *From where do you draw strength and courage?*
- *Who supports you and how?*
- *How can you use your support network?*
- *What new things did you discover about yourself (and about other family members) when travelling from home to here?*
- *How much do you believe that you will be able to rebuild a meaningful life for yourself and your family?*

Myth. Children are inevitably traumatized by war and adversities associated with being a refugee, and consequently remain mentally vulnerable for the rest of their lives.

Reality. War is traumatic for all children. The exclusive emphasis on their vulnerability however, victimizes them and ignores the resilience that many children develop both, despite the adverse conditions they encounter, as well as because of their exposure to them.

5

Children in need of specialized support

Refugee children are four times more likely to develop mental health problems as compared to the general population (Fazel & Stein, 2003). Given that post-traumatic stress disorder (PTSD) and depression are the two most common problems, we have chosen to focus on these two conditions.

To reach a comprehensive understanding of a child's needs, it is essential first to observe their behavior, listen to their emotional and physical complaints, engage in discussion with the child and/or the parents and share information with caregivers and mental health specialists. Specialized support also needs to be offered to parents when they adopt ineffective strategies (e.g. corporal punishment, withdrawal with consequent neglect of children) or who are themselves diagnosed with severe mental health problems.

5.1 Post-traumatic stress disorder (PTSD)

PTSD refers to a psychiatric disorder that may develop when a child has experienced or witnessed a traumatic or life-threatening event, or has been informed that a close friend or relative was exposed to a life-threatening traumatic event. Even without being exposed to traumatic events, some young children may manifest post-traumatic stress symptoms when their mother suffers from PTSD.

A child with PTSD is trapped in a vicious cycle in which involuntary, intrusive and overwhelming memories of the traumatic event are suppressed, with the result that the traumatic experience remains unprocessed. As long as the experience remains unprocessed, it will resurface in the consciousness through intrusive images, flashbacks and nightmares, triggering the re-living of the fear, horror, despair and extreme reactions that the child experienced during their exposure to the traumatic event. This cycle of suppression and involuntary resurfacing will recur repeatedly.

Figure 3. The vicious circle of post-traumatic stress disorder

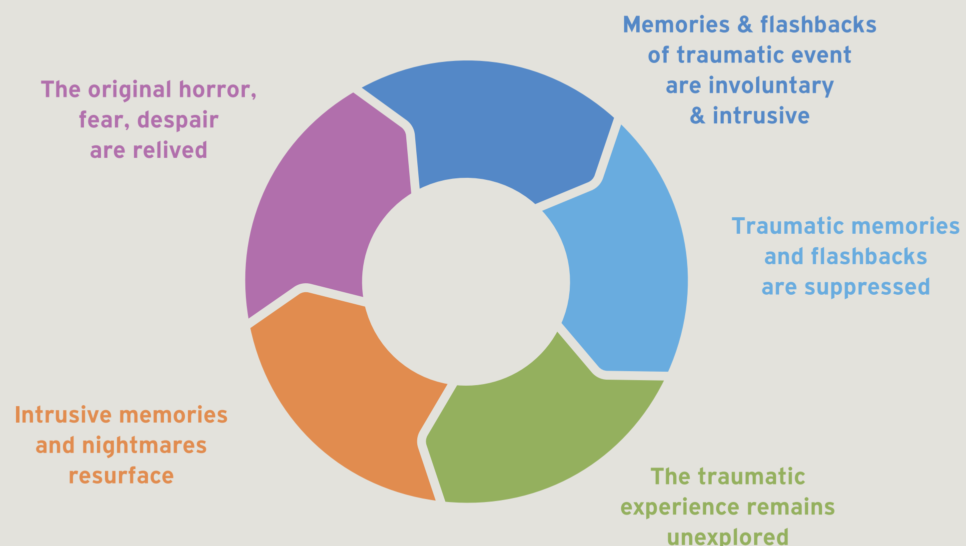


Table 2 displays some persistent symptoms of PTSD that affect the child's daily functioning for at least one month.

Table 2. PTSD symptoms in child and adolescent
(American Psychiatric Association, 2013)

1. Re-experiencing traumatic event

- *Recurrent, involuntary and intrusive memories (thoughts or images). These may also be manifested in the child's post-traumatic, compulsive re-enacting of aspects of the traumatic event, without leading to relief of their anxiety.*
- *Re-living of the event (flashbacks) and/or re-enactment of the event in play or drawings*
- *Traumatic nightmares without the content being necessarily related to the trauma*
- *Intense or prolonged distress after exposure to traumatic reminders (e.g. loud noises, fires, ambulance)*
- *Marked psychophysiological reactions after exposure to trauma-related stimuli*

2. Avoidance of trauma-related stimuli after the trauma

- *Avoidance of trauma-related thoughts and feelings*
- *Avoidance of trauma-related external reminders (e.g. people, places, situations)*

3. Negative alterations in cognitions and mood

- *Inability to recall key features of the trauma*
- *Feeling detached or estranged from others. Pre-school age children may withdraw from play.*
- *Negative thoughts and assumptions about oneself or the world (e.g., "I am bad," "The world is dangerous")*
- *Exaggerated blame of self or others for causing the traumatic event or for the resulting consequences*
- *A limited range of emotions, and persistent inability to experience positive emotions*
- *Negative trauma-related emotions (e.g. fear horror, anger, guilt or shame).*
- *Decreased interest in engaging in significant (pre-trauma) activities*

4. Alternations in arousal and psychophysiological reactivity

- *Irritability or aggression*
- *Self-destructive or risky behavior*
- *Hypervigilance to threat*
- *Heightened startle effect response*
- *Difficulty concentrating*
- *Difficulty sleeping*

In addition, the child may experience high levels of depersonalization (e.g. feeling as if "this is not happening to me" or "it was as if I was in a dream") and/or derealization which includes a sense of unreality, distance, or distortion (e.g. "things are not real").

The PTSD may be acute, with duration of symptoms from at least one to three months or chronic, with duration of symptoms of more than three months or of delayed onset, with symptoms occurring at least six months after the traumatic experience.

5.2. Depression in children and adolescents

Depression is a serious mental health condition. It is an emotional disorder that affects the ways the child feels, thinks and behaves and bodily functions such as sleep and appetite. It has a severe impact on the child's functioning at home, school or in relationships with other people (Table 3).

Depression as an emotional disorder differs from being in a "bad mood", feeling sad or grieving, responses which are commonly associated with losses that the child experiences. The rates for depression vary greatly among studies and range from 16 to 50%, often co-existing with PTSD and anxiety disorders (Bean et al., 2007; Derluyn

& Broekaert, 2007; Goosen et al., 2014; Jakobsen et al., 2014; Vervliet et al., 2014). They are more elevated among unaccompanied minors, children whose mother is depressed, and youngsters who are separated from their parents.

Table 3. Depression symptoms in children and adolescents

At least five of the following symptoms, including the first one, negatively affect the child's everyday functioning for at least two weeks.

1. *Persistent depressed mood and feeling of despair for most of the day.*
2. *Markedly diminished interest in activities that were pleasurable until recently.*
3. *Diminished ability to concentrate or make decisions.*
4. *Sleep difficulties (e.g. insomnia, waking several times at night, waking early in the morning or sleeps for many hours).*
5. *Changes in eating habits (decrease or increase in appetite) or decrease in weight (or failure to make the expected weight gain).*
6. *Fatigue or loss of energy.*
7. *Feelings of worthlessness (e.g. "I am worthless") or excessive or inappropriate guilt (e.g. "It's my fault for what happened").*
8. *Recurrent thoughts of death or suicidal ideation, attempt at suicide, or displays of self-destructive behavior.*
9. *Psychomotor retardation in speech and movement or agitation (anxiety, irritability, anger, confusion).*

The clinical presentation in children who suffer from depression differs according to their developmental level. Below are some common manifestations:

Preschool-aged children: They display regressive behavior, separation anxiety, clinging to the mother or significant others, and fear of abandonment.

School-aged children: They present a persistent depressive mood, tearfulness, anxiety or fear of separation, feeling of boredom (report they are bored) and diminished drive to do things, even to play. In addition, they often report physical complaints (e.g. headaches, tummy aches). They are irritable and have difficulties dealing with even small disappointments. They tend to become isolated from others and withdraw into themselves. They display an increased sensitivity to rejection, critical statements or failure and feel that no one loves and cares for them. They may strongly react or be negative towards everything.

Adolescents: They may express their depression through aggression (e.g. bullying), risky behaviors (e.g. alcohol and/or drug use) and antisocial behaviors (e.g. vandalism, rape). They may display sudden changes in mood and behavior, ranging from withdrawal and passivity to extreme impulsivity and hyperactivity. They often experience emotional exhaustion or anxiety, feelings of helplessness (e.g. "I am weak", "I do not have control", "I am vulnerable") and hold negative and hopeless thoughts, in particular about the future (e.g. "things will never change").

When should the child or adolescent be referred to a mental health specialist?

- *When a child or adolescent presents symptoms that cause significant impairment in everyday functioning (e.g. significantly neglects their appearance and personal hygiene and isolates themselves from others).*
- *Thinks about death and expresses it directly or indirectly through a drawing or through disclosure to a person close to him.*
- *Isolates him or herself from friends and family, does not share thoughts with others*
- *Resorts to alcohol or drug use*
- *Engages in self-harm*

5.3. Suicidal Risk

When a child or an adolescent talks about suicide, the risk is real. A suicide attempt should not be viewed as an attempt to "seek attention" from others or to "manipulate" the environment. It is desperate cry for help.

The risk assessment is of paramount importance, given that parents often don't notice the indications, and adolescents avoid talking directly about their suicidal tendencies. It is important that the investigation of suicidal thoughts/states of mind or suicidal behavior is carried out gradually/progressively as in some cultures suicide attempts and suicide are associated with stigma, shame and social marginalization (UNHCR, 2015).

Some questions to help assess suicidal risk

- *Have you ever thought that this life is not worth living?*
- *Have you thought that death would be better than this life?*
- *Are there moments that you wish God would let you die?*
  If yes, *have you ever thought of ending your life, as some people think?*
  If yes, *have you made plans about how you would like to put an end to your life?*
  If yes, *what plans have you made?*
- *Have you ever, in the past, tried to end your life?*
  If yes, *what did you do? What happened afterwards?*
- *Have you ever, in the past, tried to harm yourself?*
  If yes, *when did this happen? What was the outcome of your self-harming behavior?*

6

Death and mourning rituals

6.1. Cultural and religious "heritage"

Grieving the loss of a significant person is universal. Nevertheless, each culture and religion has its own set of beliefs, norms and rituals designed to integrate the bereaved into the world of the living, to regulate the bereaved person's manifestations of grief and to determine the society's expected behaviors toward mourners (Parkes, Laungani & Young, 2015, Walter, 1999).

Even though we may not know the cultural and religious rituals, beliefs and practices of each family we support, it is significant to discover what is important to family members regarding bereavement and mourning rituals, the meaning(s) attributed to the death of a significant person and the nature of the relationship maintained with the deceased person.

A culture is rarely homogeneous in how it determines who is responsible for the care of the dead body, who should participate in the mourning rituals, which grief manifestations are expected by whom and for how long (Walter, 2010). While some cultures integrate the dead into the life of the living, others promote a distinct separation and as a result construe the bond with the deceased differently (Walter, 1999). A few indicative examples of different cultural and religious traditions are described:

In countries where Islamic traditions prevail, death is perceived as God's pre-determined will and should not be questioned. Once the dead person has been washed and swathed in white garments by women, the body is placed without a coffin in the earth. Only men attend the funeral ceremony. For the duration of the next 7 days, relatives, friends and neighbors bring food to family members and participate in mourning by encouraging narratives about the deceased.

In cultures where other religions prevail (e.g. Buddhism, Confucianism, Taoism), the oldest members of the family undertake the funeral ceremony. The deceased is dressed in warm clothes and placed in a coffin, often along with a meal, which is regarded as the last for him or her and is also for the spirits accompanying him or her. To honor the spirit of the deceased, and thank those who attended the ceremony, the family provides a meal after the burial.

In other cultures, which draw on practices from different religions, relatives and friends gather at the home of the deceased person and join in the wake with songs, hymns, and music. The following day, a service is held to commemorate the deceased person's return to God/Christ and his or her reunion with relatives and friends who have gone before. The burial is followed by a meal.

Some cultural or religious traditions limit the open expression of intense suffering to the first few days after the death out of fear of hindering the soul in its departure. Others set different rules for the expression of emotion by men and women, and/or among people who belong to different social classes.

6.2. Assessing the particular characteristics of a family's mourning

The following questions may contribute to a better understanding of the cultural and religious beliefs, traditions and rules that affect the mourning process of a refugee family grieving the loss of its member(s).

What relationship is maintained with the deceased?

Is the bond maintained and if so, how is it developed over time? Is the soul of the deceased handed to his or her ancestors through specific rituals? Is gradual emotional release from the deceased and investment in new relationships and goals encouraged?

How are the dead handled?

What rituals precede burial or incineration? Who take on key roles and participates? What do their rituals involve? Is the burial site to be visited or avoided? How the memory of the deceased is kept alive? What are the roles and qualities attributed to the deceased, especially if he or she died in war or national conflicts?

What are the responsibilities of mourners?

What responsibilities and ritual obligations do the relatives have to the person who died? Who assumes the care of the dead? Do relatives undertake the support of the deceased person's next of kin? Do they focus on their own adjustment to the new life conditions that arise after the loss? Are children informed of death? Do they participate in the rituals?

Who should be mourned and for how long?

Are infants mourned? Children? Adults? The elderly? Ancestors? How long does the mourning last for different family members and how long for leaders, national heroes or those killed on the battlefield? What is the expected expression of such mourning?

How should emotions be expressed?

Should the mourners' emotions be expressed or held back, even within the home of the bereaved family?

What are the prevailing beliefs about the suffering of the bereaved?

To what extent do religious or other dominant belief systems, normalize or pathologize grief and which manifestations are perceived as deviant? Is the narration of stories about the deceased encouraged? How do these narratives fit into wider social narratives shaped by war, conflict, persecution or genocide?

Should mourners be socially excluded or included?

Are there rituals for the integration or temporary exclusion of the bereaved? How their new social position as "bereaved" encouraged is and what responsibilities do they assume? When and how are they marginalized?

6.3. Psychological support for the bereaved

It is important to differentiate the goals and methods of psychological support adopted in western cultures from those applied to populations of different cultures. Western cultures often encourage the privatization of grief which unfolds within the confines of the family; mourning is a social event only during the first days post death. This privatization often leads the bereaved to seek support among mental health professionals who specialize in bereavement. Through bereavement support, they are encouraged to express their emotions openly and to "work through" their grief so as to adjust to the new reality, "move on" with life, and concurrently maintain an internalized, ongoing bond with the person who died. Diversity is encouraged. Therefore different manifestations of grief and "trajectories" in the process of bereavement are encouraged, reflecting the individualistic values of western cultures that promote freedom and self-determination.

In other cultures, these goals and methods of psychological support may not always be acceptable. Mourning and the expression of suffering are governed by strict social rules, rituals and customs that define how one should mourn, express feelings, and behave in pursuit of maintaining or forgetting the memory of the deceased. Each culture determines how community members should behave and what obligations they have towards the members of the bereaved family. Behaviors that appear pathological in our own culture may be acceptable as normal and desirable in other cultures (e.g. being expected to forget a dead child, complete disconnection from the place of burial, immediate marriage of a widow with a member of her husband's family).

Interventions that aim to support children and families must be guided by at least four basic principles:

(a) Understanding of the cultural and religious beliefs, traditions and rules that affect the family's mourning. Speculations linking a refugee's ethnicity with specific cultural practices, religious beliefs, attitudes and rituals should be avoided since he or she may not be religious or adhere to all of them.

(b) Ensuring conditions that facilitate a normal grieving process.

- By organizing rituals that make sense to family members,
- By sensitizing parents to children's normal grief reactions so as to facilitate their mourning process
- By creating a supportive and holding environment that contains suffering and facilitates changes in family relationships, as well as in the attribution of meaning to their loss so that it can be integrated into the family's story.

(c) Respecting the unique rhythm and way that family members choose to grieve or to suppress their grief when simultaneously, they have to manage difficulties and adversities (e.g. security issues, survival).

(d) Recognizing the potential conflict between personal needs and cultural, religious and family aspirations and norms. For example, a 12-year-old boy who wants to cry upon learning about the death of his father is in conflict with cultural and ethnic norms according to which "men should not cry", and also family expectations that he has an obligation to assume a "leadership" role in the family. In such a case, enhancing the mother's awareness of common grief reactions of children, together with the child's willingness to participate in creative activities, may facilitate the direct or indirect expression of emotions, alleviate suffering and relieve guilt.

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